IN THE MATTER OF ARBITRATION BETWEEN

Fairview Oxboro & Ridges Clinics, Fairview Health Services	**) FMCS Case No. 06-1227-52360-7**
	) Issue: Health Insurance
"Employer"	**)**
	) Hearing Date: April 26, 2006
and	**)**
	) Briefing Date: June 29, 2006
Services Employees International Union (SEIU), Local No. 113	**)**
	) Hearing Site: Minneapolis, MN
"Union"	**)**
	) Award Date: August 29, 2006
	)
	) Mario F. Bognanno, Arbitrator

JURISDICTION

Pursuant to relevant provisions in the parties' Collective Bargaining Agreement, this case was heard on April 26, 2006, in Minneapolis, Minnesota. (Joint Exhibit 1).The parties appeared through their designated representatives who waived the 30-day decision-making period referenced in article 9 of their Agreement. Both parties were afforded a full and fair opportunity to present their respective cases. A verbatim transcription of the hearing was prepared. Witness testimony was sworn and subject to cross-examination. Exhibits were introduced into the record. The parties submitted post-hearing briefs on or about June 29, 2006, at which time the record of this case was officially closed. Thereafter, the undersigned took this matter under advisement.

APPEARANCES

For the Union:

Brendan Cummins	Attorney at Law
Julie Schnell,	President, SEIU, Local No. 113

Karmen Lee Ortloff	Business Representative, SEIU, Local No. 113
Shane Davis	Business Representative, SEIU, Local No. 113
Dianne Edwards	Business Representative, SEIU, Local No. 113
Jon Youngdahl	Executive Director, SEIU State Council
Holly Rodin	Field Researcher, SEIU, Local No. 113
Tracy Stankovich	Charge Nurse, Fairview Ridges Clinic
Peggy Meyer	Patient Representative, Fairview Ridges Clinic

For the Employer:

Jan D. Halverson	Attorney at Law
Thomas R. Trachsel	Attorney at Law
John Erickson	Director, Employee & Labor Relations, Fairview Health Services
Charles E. Felion	Benefits Manager, Fairview Health Services
Barbara Eischen	Director, Health & Benefits, Fairview Health Services
Mary Beth Percy	Consultant, Labor Relations, Fairview Health Services
Jamie Hornibrock	Administrator, Fairview Ridges Clinic
Catherine Neary	Human Resources Representative, Fairview Ridges Hospital
Sue Peterson	Senior Human Resources Representative, Fairview Southdale Hospital

I. FACTS AND BACKGROUND

Fairview Health Services is a Minnesota-based health care system, employing approximately 19,000 employees. It is comprised of seven (7) hospitals, multiple clinics, and various other health care services. The Employer, Oxboro & Ridges Clinics, operates health care clinics in Burnsville, MN and Bloomington, MN that together employ approximately 142 benefit-eligible bargaining unit employees. (Tr. 121 – 122). SEIU, Local 113, the Union, and the Employer have nearly a 20-year bargaining history.

During the November - December 2004 period, the parties negotiated their current Collective Bargaining Agreement, which was made effective from March 1, 2005 through February 29, 2008. (Tr. 102 – 103; Tr.174). Among the issues negotiated were adjustments to article 7 – Insurance Benefits. Specifically, the Union proposed that the Employer-paid share of insurance benefit premium costs be increased, and the Employer proposed to eliminate the so-called Oxboro and Ridges medical clinics' "discount". Ultimately, it was agreed that the Employer's share of "single plus one" and "family" coverage would be increased from 65% to 70% effective January 1, 2006; and the Employer agreed to maintain the Oxboro and Ridges clinics' discount. (Joint Exhibit 1; Tr. 102 –103 and Tr.174). Significantly, there were neither substantive negotiations about changes to the Employer's 2005 health insurance plans, nor about MedChoice – the looming health insurance plan that the Employer was planning to implement at some

future point in time.[1] Moreover, in their negotiation of the 2005 – 2008 Agreement, the parties did not revise or alter the content of article 7(A)(1), which reads as follows:

> The Employer will provide comprehensive hospitalization, medical-surgical benefits and major medical insurance which shall be substantially similar to the benefits that are in effect as of the effective date of this Contract.

(Joint Exhibit 1). A review of previous contracts between the parties makes clear that this language first appeared in their March 1, 1990 – February 28, 1992 Collective Bargaining Agreement. (Union Exhibit 18). In late 1992, the Employer proposed that it become self-insured: a proposal that ultimately passed bargaining muster with the Union. (Union Exhibits 19, 20 and 21).

Between 1992 and January 1, 2006, the Employer offered employees a choice among three (3) pre-packaged health insurance plans, contemporarily known as the Care Team, High Deductible and Open Access plans. While each of these plans provided for single, single plus one (1) dependent (i.e., employee plus spouse or domestic partner) and family (employee plus one (1) dependent and children) tiers of coverage, their other terms, including the amount of employee-paid premium costs, often differed. From time-to-time during the 1992 – 2006 period, the Employer would make adjustments and modifications to these three (3) plans, sometimes changing plan names, changing prescription drug, office visit, hospital inpatient and hospital outpatient co-payment amounts, improving service coverage, changing co-insurance percentages and out-of-

[1] At this point, it is sufficient to observe that MedChoice is the name of the new 2006 health insurance plan that the Employer was in the process of designing at the time the current Agreement was being negotiated.

pocket maximums for the non-Care Team plans, and adding the single plus one (1) tier. (Employer Exhibit 15; Tr. 160 – 169). None of these periodic charges to the health insurance plans were challenged under "substantially similar" language in article 7(A)(1). (Tr. 161).

During the summer of 2005, the Employer was in the process of finalizing plans to implement a new health insurance plan – MedChoice – that was to become effective on January 1, 2006. Relative to the 2005 health insurance plans, MedChoice incorporates a new "flexible benefit" or "customized" design that requires a myriad of employee coverage, co-insurance, co-pay, and deductible choices, as well as redesigned coverage tiers. As a result, on September 19, 2005, the Union filed a grievance alleging, *inter alia*, that the Employer's plan to unilaterally implement MedChoice was an article 7(A)(1) violation. (Joint Exhibit 2).

John Erickson, Director of Employee and Labor Relations, testified that in July/August 2004, he told Karmen Ortloff and Dianne Edwards, SEIU, Local 113 Business Representatives, that the Employer was considering a potentially new health insurance plan. (Tr. 171 - 172). Several months later, on June 7 and June 10, 2005, respectively, Mr. Erickson testified that he told Ms. Edwards and Shane Davis, SEIU, Local 113 Business Representative, that health insurance was "…on the table…" because the Employer was nearly ready to implement its new 2006 health insurance plan. Subsequently, Mr Erickson faxed a copy of a document entitled "Benefits Overview" to the Union representatives. This document sketches the numerous decisions that employees would have to make

during their open enrollment period.[2] (Employer Exhibit 1; Tr. 175 – 178). On August 5, 2005, Mr. Erickson met with Ms. Edwards, updating her on the Employer's plan to launch an extended six (6) week open enrollment period for new health insurance plan; and on August 8, 2005, he faxed her a copy of a Fairview newsletter that outlines the Ultimate Choice benefits, explains why the Employer was shifting to the new plan, and introduces the Ultimate Choice web site. (Employer Exhibit 3; (Tr. 178 – 179). On August 9, 2005, Barbara Eischen, Director of Health and Benefits, presented an "overhead" version of the Ultimate Choice plan to James Bialke, the Union's health insurance information coordinator. Mr. Erickson was in attendance at that presentation. (Employer Exhibit 12; Tr. 180 – 181). As footnoted, Ultimate Choice includes a MedChoice component.[3] In a letter dated August 11, 2005, Mr. Bialke put a number of questions to Mr. Erickson and he requested additional information about MedChoice. (Union Exhibit 28). In a reply letter dated September 15, 2005, Mr. Erickson answered some of Mr. Bialke's questions and he attached several documents designed to answer the balance of Mr. Bialke's questions. (Union Exhibit 1 and Union Exhibit 28).

On September 18, 2005, the Union grieved the Employer's decision to proceed with employee-enrollment under the MedChoice health insurance plan,

[2] Actually, the document refers to the "Ultimate Choice" plan: the name given to the Employer's new 2006 package of comprehensive benefits that was to be made available to all non-contract employees. In addition to including paid time off benefits, life insurance, and short- and long-term disability benefits, it also includes the MedChoice health insurance plan. However, the Employer intended that both contract and non-contract employees would be covered by the MedChoice health insurance component of Ultimate Choice. (Union Exhibit 16; Tr. 126 – 127).

[3] It appears that at about this same time, Catherine Neary, Human Resources Representative, presented a similar overview to Mr. Davis and a group of Union stewards at the Oxboro Clinic. (Tr. 180 – 182).

which was to commence on October 3 and end on November 16, 2005, and to its planned implementation on January 1, 2006. (Joint Exhibit 2; Tr. 195 – 196). The grievance cover letter is signed by Union Stewards Tracy Wallis and Sharon Kohser. Therein, they allege that the Employer's unilateral changes to health insurance violates the parties' contract and, specifically, that the changes violate articles 1 (Recognition), 3 (Management Rights) and 7 (Insurance Benefits). With respect to the charged violation of article 7 (i.e., the "substantially similar" language quoted earlier), the Union stewards' write:

> The new health plan is radically different from the current health insurance plan. The new plan institutes a substantial reduction in benefits and is designed to confuse and complicate insurance coverage to the detriment of the employees covered by this Agreement.

(Joint Exhibit 3). At a meeting to discuss this grievance, the Employer made a settlement offer that was rejected by the Union, and the matter proceeded to arbitration. (Joint Exhibits 6 and 7; Tr. 185 – 188).

On October 30, 2005, the Union filed an unfair labor practice charge with the National Labor Relations Board (NLRB), alleging that the unilateral implementation of MedChoice constitutes a violation of 8(a)(5) of the National Labor Relations Act (NLRA). (Joint Exhibit 4). In a letter dated November 9, 2005, the NLRB deferred the charge to arbitration, and reminded the Union that the arbitration award may ultimately be submitted to the NLRB for review. (Joint Exhibit 5).

The record is rich in detailed information describing the MedChoice plan and its predecessor pre-packaged plans, namely: Care Team; High Deductible; and Open Access. (See Employer Exhibits 1 – 9 and Union Exhibits 2, 3 and 6,

for example). A discussion of benefit similarities and differences among these plans will follow with greatest emphasis given to a comparison between the Care Team and MedChoice plans – the most relevant plans. The reasons for this narrowed emphasis are threefold:

(1) Among the 106 employees who chose to participate in the 2005 insurance plans, 79 or 74.5% elected to participate in the Care Team Plan; 7 or 6.6% in the High Deductible Plan; and 20 or 18.9% in the Open Access Plan. Further, within each coverage tier, the preponderance of participants elected Care Team. (Union Exhibit 1).

(2) The 2005 Care Team Plan had higher benefit levels than did either the High Deductible or Open Access plans, as measured in terms of Care Team's unique $0 deductibles, 100% co-insurance and lowest out-of-pocket maximum features. Moreover, the participants in the 2005 health insurance plans who elected to participate in the 2006 MedChoice Plan proceeded to create "customized" plans that exhibit Care Team-like higher benefit levels. That is, 100 or 91% of the employees covered in 2005 created 2006 plans that incorporated the following MedChoice features: $0 deductibles, 90% co-insurance (the next best option to 100% co-insurance: an option not available under MedChoice), and lowest the out-of-pocket maximums. (Employer Exhibit 9).

(3) The data in this case are so voluminous that its presentation could prove to be unwieldy without imposing some conditional limitations on its analysis. Because nearly three-fourths (3/4ths) of insured employees in

2005 were enrolled in the Care Team Plan, the weight of changes to health insurance benefits, whether positive or negative, will disproportionately fall on the enrollees in this plan. Thus, a great deal of the data in evidence also focuses on this same two-way comparison.

Table 1 in appendix A to this Award presents an abbreviated comparison between the 2005 Care Team Plan and 2006 MedChoice Plan, to the exclusion of the 2005 High Deductible and Open Access plans. The purpose of this table is to provide a synopsis of the plans overall designs and benefit features.

[Reference table 1]

Before delving into this two-way comparison, a few words about the similarities between the 2005 High Deductible, 2005 Open Access, and 2006 MedChoice plans *vis a vis* Care Team are in order. Relative to Care Team, these three (3) plans:

- offer(ed) access to a larger network of providers;
- require(d) annual deductibles;
- have (had) higher maximum out-of-pocket limits;
- offer(ed) less than 100% co-insurance coverage for office visits, prescription drugs, and inpatient and outpatient hospital service; and
- generally offer(ed) lower premiums as the trade-off for higher annual deductibles, higher out-of-pocket maximums, and less than 100% co-insurance. (See, for example, Union Exhibits 9 and 10; Employer Exhibit 10).

Care Team vs. MedChoice

As evidenced in table 1, the design and coverage features of Care Team and MedChoice are quite different. The former was a "managed care" plan; whereas, the latter is an "employee created plan", with a much larger network of providers. Under MedChoice employees create customized health insurance plans that fits their personal needs, resources and risk preferences. That is, MedChoice participants can select that specific combination of out of pocket maximums and annual deductible amounts,[4] co-insurance,[5] office visit co-pay,[6] and prescription drug coverage levels that optimize their personal/family welfare by balancing the trade-off between paying higher (lower) health insurance premiums in return for prospectively lower (higher) out-of-pocket medical charges during a year. (Employer Exhibit 4). In contrast, the Care Team Plan was totally pre-packaged. (Union Exhibit 2).[7]

The discussion of the more salient distinctions between the two (2) plans can be neatly organized around the referenced four (4) MedChoice features enumerated above.

[4] An out-of-pocket maximum is the most an employee would have to pay for eligible medical charges during a calendar year; whereas, the annual deductible is the amount of eligible medical charges that is paid by the employee before the insurance plan starts paying benefit-costs.
[5] Co-insurance is the percent of an eligible medical charge that is paid by the insurance plan, after the employee has paid any applicable deductible.
[6] A co-payment is a flat dollar amount paid by the employee for eligible medical charges.
[7] Of course, the 2005 pre-packages High Deductible and Open Access plans were also available for employees to choose. These plans provided access to more providers. Both plans incorporated deductible, co-pay and co-insurance features. The High Deductible Plan provided for catastrophic coverage following the payment of a high deductible. Its premium costs were relatively lower than the Open Access Plan's, as the latter's deductibles were considerably less. (Employer Exhibit 14).

1. Out-of-Pocket Maximums and Annual Deductible Levels

MedChoice offers six (6) annual deductible levels – $0, $300, $600, $1,000, $1,200, and $2,500 deductible levels. The Care Team Plan's annual deductible was $0. (Union Exhibits 4 and 6; Tr. 122 – 123).

The MedChoice out-of-pocket dollar maximum depends on the employee's annual deductible level and coverage tier choices. For example, at the $0 deductible level with employee-only coverage the out-of-pocket maximum is $1,500, increasing to $3,000 for employee plus two (2) or more covered dependents. Whereas, at the $2,500 deductible level with employee-only coverage the out-of-pocket maximum is $4,000, increasing to $8,000 for employee plus two (2) or more covered dependents. As shown in table 1, under the Care Team Plan, the maximum out-of-pocket employee expenses were $1,000 for employee-only coverage, increasing to $2,000 for employee plus one (1) dependent and for family coverage. (Union Exhibits 2, 4 and 6; Employer Exhibit 4; and Tr.122 – 123).

2. Co-insurance Levels/Options

MedChoice offers two (2) co-insurance levels/options – 90%/70%/60% and 80%/60%/50%, depending on whether the selected provider is in the Choice network, Preferred One network, or out-of-network, respectively. Co-insurance payments are not counted against the employee's deductible level. Whereas, Care Team co-insurance was 100% for in-network physician care, and 100% for hospitalization at

Fairview hospitals and the North Memorial hospital, and 80% at other network hospitals. (Union Exhibits 2, 4 and 6, and Employer Exhibit 4; Tr. 123; and table 1 – “Inpatient Hospital Services”)

3. Office Visit Co-Pay Levels

MedChoice offers three (3) co-pay levels – $0 co-pay (only annual deductible and co-insurance apply), $15 co-pay (before co-insurance), and $25 co-pay (before co-insurance) levels, and then co-insurance kicks in. As suggested in table 1, office co-pays do not count toward an employee’s annual deductible level or out-of-packet maximum. In contrast, the Care Team Plan required $15 co-pay for primary and specialized physician office visit care, urgent care and therapy; $100 and $40 co-pay for inpatient and outpatient hospital services, respectively; and $40 co-pay for emergency room visits that do not result in a hospital admission. (Union Exhibits2, 4 and 6, and Employer Exhibit 4; Tr. 123).

4. Prescription Drug Benefit Levels

With respect to prescription drugs, MedChoice provides for two (2) levels – either pharmacy costs apply toward the annual deductible and out-of-packet maximum, or pharmacy costs neither apply toward annual deductible nor out-of-pocket maximum. In addition, there is a 80%/75%/70% and 70%/65%/60% co-insurance benefit for generic/formulary/non-formulary prescription drugs purchased at Fairview and other network pharmacies, respectively. As depicted in table 1, these co-insurance percentages are bracketed by minimum and maximum dollar

outlay amounts. On the other hand, the Care Team Plan called for flat dollar co-payment amounts for generic/formulary/non-formulary prescription drugs, as shown in table 1. (Union Exhibits2, 4 and 6; Employer Exhibit 4; Tr. 124; and table 1 – "Prescription Drugs").

Within the framework of these four (4) choice factors, the record of witness testimony is that MedChoice offers employees 52 different health insurance plan combinations, each of which carries a different premium cost. (Union Exhibit 4(c)). In addition, premium costs are affected by the number/age of individuals covered by each plan. In 2005, the Employer offered three (3) coverage tiers for health insurance: employee; employee plus one (1) spouse/partner; and family. Thus, for example, under the Care Team Plan a single mother with two (2) children and the married mother with spouse and four (4) children would pay the same premium cost, namely, $318.48 monthly in 2005 dollars. (Employer Exhibit 10).

However, under MedChoice there are ten (10) coverage tiers: employee; employee plus one (1) spouse/partner; employee plus one (1) child; employee plus two (2) children; employee plus three (3) children; employee plus four (4) or more children; employee plus spouse and one (1) child; employee plus spouse and two (2) children; employee plus spouse and three (3) children; and employee plus spouse and four (4) or more children. Accordingly, given the same highest benefit plan design[8], a single mother with two (2) children will pay a monthly premium of $209.80; whereas, a married mother with a spouse and four (4)

[8] That is, a plan design that includes the following features: $0 deductible, 90%/70%/60% co-insurance, $0 co-pay, and Rx subject to deductible.

children will pay $419.60 in 2006 monthly premiums. (Employer Exhibits 4 and 10; Tr. 134 – 135).

II. The Issue

The core issue in this case may be framed as follows:

Did the Employer violate article 7(A)(1) in the Collective Bargaining Agreement when it implemented the MedChoice health insurance plan on January 1, 2006? If so, what is an appropriate remedy?

III. RELEVANT CONTRACT PROVISIONS

Article 7 – Insurance Benefits

(A) Health Insurance

1. The Employer will provide comprehensive hospitalization, medical-surgical benefits and major medical insurance which shall be substantially similar to the benefits that are in effect as of the effective date of this Contract. Employer shall pay eighty percent (80%) of the cost of single coverage on behalf of employees enrolled in the plan.

2. Full-time and regularly scheduled part-time employees working twenty (20) or more hours per week shall be eligible for such health insurance.

3. Employees covered by the health insurance plan shall be offered the opportunity to purchase dependency coverage. The Employer shall contribute sixty-five percent (65%) of the total premium for family coverage.

   The Employer shall contribute sixty-five percent (65%) of the total premium for single plus one coverage. Effective January 1, 2006, the Employer's contribution shall change so that the Employer contributes seventy percent (70%) of the total premium for single plus one and family coverage.

(B) Oxboro and Ridges Clinics Discount

1. Discounts shall be provided, after completion of the probationary period, to the employees or immediate dependents under the care of an Oxboro and Ridges staff physician or Locum Tenens. The term "immediate dependent" as used in this article shall be defined in the

health plan. A discount applies only after all insurance benefits have been fully utilized. The employee discount is available only for employees and dependents covered by a health plan who file their insurance claims on a timely basis. In addition, no discount shall be available for employees or their dependents for Oxboro and Ridges care for out-of-network service.

2. Permanent full-time employees and regular part-time employees working thirty (30) hours per week, spouses and immediate dependents – 100% discount.

3. Regular part-time employees working less than thirty (30) hours per week, spouses and immediate dependents – 50% discount if the employee works a minimum of twenty (20) hours per week. A 25% discount will be allowed if the employee works less than twenty (20) hours per week and more than ten (10) hours per week. The average number of hours worked per week will be computed on the basis of total hours worked during the three (3) months immediately preceding the month of service.

(Joint Exhibits 1).

IV. POSITION OF THE UNION

The Union argues that the Employer's January 1, 2006, unilateral implementation of the MedChoice is a "transformational change" relative to Care Team – a characterization that Charles Felion accepts. (Tr. 157). Moreover, MedChoice is a "customized" or "flexible benefit" plan as opposed to the 2005 "pre-packaged" plans, which represents a first-ever plan redesign – a characterization agreed to by Barbara Eischen, Director of Benefits and Health. (Tr.167). The Union continues with the assertion that relative to Care Team, the MedChoice Plan shifts more risk and health care cost-sharing to employees because it eliminates Care Team's 100% co-insurance feature and dramatically increases employee out-of-pocket maximums. Further, MedChoice, the Union points out, is structurally biased against families with several children because

the annual premium costs increase linearly as family size increases to two (2), three (3), and four (4) children; whereas, under the previous plans, annual premium costs for family coverage was invariant with respect to family size. (Union Exhibit 10). For these reasons, the Union urges, that MedChoice's and Care Team's benefits are not "substantially similar", as required by article 7(A)(1).

Next, citing *Bison Gear and Engineering*, 2002 WL 3514489 (Vernon, 2005), the Union contends that MedChoice is not "substantially similar" to previous plan benefits because the changes it introduces are not "minor changes". Further, the Union argues that the effects of the plan changes may neither be "cost neutral" nor result in "cost savings to employees". *Whayne Supply Co*., 111 LA 940 (Imundo, 1998). Rather, the Union argues, MedChoice subjects employees with large families to higher premium costs, and it subjects all employees to higher co-insurance payments and to higher out-of-pocket maximums. Still further, the Union contends that under MedChoice the multiple levels of plan features are so varied that it cannot possibly be concluded that they remain substantially similar to Care Team's plan features. *South Central Power Company*, 2004 WL 2146194 (Fullmer, 2004).

Specifically, the Union points out that MedChoice, unlike Care Team, is replete with health care cost-shifting features, subjecting employees to greater illness-related economic risks. Namely, MedChoice does not offer (a) 100% co-insurance, as did Care Team; (b) its out-of-pocket maximums are dramatically higher; (c) although MedChoice's co-pay choices vary from $0 to $15 and $25,

depending on employee choice, co-pays do not count toward out-of-pocket maximums and thus, the employee continue to make co-payments even after maximums are reached; (d) Care Team had no deductible, whereas there are multiple deductible levels under MedChoice, and co-payments and co-insurance are not counted toward the deductibles; and (e) MedChoice specifies the percent of pharmaceutical drug costs for which the employee is responsible, with minimum and maximum costs, while Care Team had fixed co-pays for prescription drugs.[9]

Further, the Union argues that relative to Care Team, cost-shifting occurs under MedChoice's emergency room, urgent care, hospital outpatient and inpatient, and mental health insured care inasmuch as the former assesses the employee nominal fixed co-payments that are sometimes waived; whereas, under MedChoice the employee is assessed co-insurance amounts. Relying on several different illustrative scenarios, the Union contends that under reasonable assumptions the MedChoice co-insurance outlays would be greater than the Care Team co-payments. (Union Exhibits 7).

Still further, the Union advances two (2) related and plan-differentiating arguments. First, with 60%, 70% or 90% co-insurance, employees will be economically deterred from accessing needed medical care; and second, with less than 100% co-insurance, employees will doubtlessly pay more out-of-pocket than in previous years, explaining why out-of-pocket levels were increased in 2006. (Union Exhibit 13; Tr. 153 – 154).

[9] Relying on reasonable assumptions, Union Exhibit 11 illustrates that for about three-quarters (3/4ths) of the top 20 medications prescribed for Fairview employees, the MedChoice payments for co-insurance would be larger than corresponding Care Team co-pay outlays. (Tr. 55 – 58).

While conceding that under most MedChoice plans premium-costs are lower than they were under the Care Team Plan, the Union argues that these savings evaporate once employees access the health care system because of the new co-insurance payment obligation of employees, among other reasons. To illustrate this point, the Union analyzes the case of Charge Nurse Tracy Stankovich, showing that her actual 2006 out-of-pocket expenses were much larger under MedChoice than they would have been under Care Team, and implicitly, that her larger out-of-pocket outlays exceed her annual premium savings under MedChoice. (Union Exhibits 22 – 27).

Finally, the Union asserts that the Employer has never in previous years undertaken such transformational changes to its health insurance plans. For this and the other reasons given, the Union's sought-after remedy it that the Employer be directed to (1) rescind the MedChoice Plan, (2) reinstate the health insurance benefits that were in effect as of March 1, 2005, the effective date of the current Agreement, and (3) make employees whole for all losses incurred as a result of the contract violation.

V. POSITION OF THE EMPLOYER

Initially, the Employer points out that it offered MedChoice for three (3) business related reasons: (1) to accommodate the unique health benefit needs of its changing workforce demographics; (2) to enhance the Employer's ability to compete in the labor market; and (3) to dampen the rapid pace of increasing medical costs through employee cost-sharing methods. With these goals in mind, the Employer argues that MedChoice has succeeded in reducing annual

premium costs for most covered employees; it has attracted enrollees rather than the opposite, as the Union's case would suggest; and it has done so while assuring that 2005 and 2006 medical benefits remained "substantially similar". (Employer Exhibit 13). Accordingly, for these reasons, Employer urges that the January 1, 2006, implementation of MedChoice did not violate article 7(A)(1) of the Agreement. But, the Employer continues, this does not exhaust the set of reasons supporting this conclusion.

First, the controlling language in article 7(A)(1) only requires the Employer to provide 2006 health insurance benefits that are "substantially similar" to the benefits in effect in 2005. The operative word is "similar", not "identical", and so overall the 2006 set of health insurance benefits need not be equal to or even better than 2005's benefits. They only need to be "substantially similar" to the 2005 benefits. The Employer concludes that the grievance lacks merit on the basis of this argument.

Second, the Employer concedes that MedChoice incorporates benefit increases in some areas and decreases in other areas, and, thus, some employees will benefit from these changes and other may not. However, the Employer contends that this does not imply that MedChoice fails to meet the "substantially similar" requirement. Any comparison of pre- and post-health insurance benefit changes, both positive and negative, must consider all changes in their "totality" (i.e., not simply turn on the basis of any particular change), and also must give weight to changes in employee-paid premiums. *Clark County Sheriff*, 118 L.A. 1494 (Graham, 2003), *Regina Medical Center* (Fogelberg,

2006), *City of Reading*, 118 L.A. 1576 (Paolucci, 2003), and *Scioto County Sheriff's Department*, 2002 WL 32502091 (Ruben, 2002). Thus, for these added reasons, the Employer contends that the Union did not meet its burden to prove that MedChoice's benefits are substantially dissimilar from the benefits that were available in 2005.

Next, the Employer examines the details of the health insurance changes that occurred between 2005 and 2006. The Employer acknowledges that while MedChoice resulted in several plan changes, other areas remained unchanged like the scope of services, 100% coverage for preventive care, and under MedChoice an employee can build a plan with $0 deductible. With respect to areas of change, the Employer argues that the conversion from three (3) to ten (10) coverage tiers is a positive change. The Employer suggests that this change is more equitable in that it more accurately reflects the true cost of covering a dependent adult or child, and the true cost of incrementally covering more children. Further, the Employer points out that the annual 2006 MedChoice premiums are lower than the 2005 Care Team premiums would have been in eight (8) of the ten (10) new coverage tiers, even assuming that all enrollees elect the highest benefit plan design. Indeed, only three (3) former Care Team enrollees are in MedChoice's two (2) higher premium cost tiers (i.e., employee/spouse/3 children and employee/spouse/4 or more children), while 66 are actually paying lower 2006 premiums. (Employer Exhibit 10). Lastly, the Employer urges that future premium-costs were on a steep upward trajectory, such that under the 2005 plans, annual premiums would have increased on

average by 7% without the implementation of the new plan. (Employer Exhibit 11; Tr. 140).

A second important modification is that under MedChoice, employees have the option to design a plan with or without co-pays, while under Care Team co-pays are mandatory: a benefit enhancement, the Employer argues. Next, the Employer concedes that Care Team provided 100% co-insurance for certain services; whereas, MedChoice's richest co-insurance option is 90% (Choice network), 70% (Preferred One network), and 60% (out-of-network). However, the Employer continues, Care Team requires a co-payment for most health care visits, while MedChoice offers a $0 co-pay option that would serve to minimize out-of-pocket payments.

With respect to the out-of-pocket maximums and customization choices facing employees, the Employer points out that MedChoice offers lower maximums than did the 2005 High Deductible and Open Access plans, and that the customization feature of MedChoice allows employees to build plans that best suit their preferences. As for prescription drugs, while MedChoice, like the High Deductible plan, provides co-insurance coverage subject to minimum and maximum amounts, it newly allows employees the option of having prescription drug payments be made subject to out-of-pocket maximums: a benefit that was not available in 2005. The Employer also identifies the following MedChoice benefits that were not provided in 2005: (1) the larger network size and newly provided out-of-network benefits; (2) an enhanced ability to self-refer to specialist care; and (3) the opportunity to create and fund a Health Savings Account.

Next, the Employer argues that the undersigned lacks the authority to determine whether the Employer violated the NLRA in this case and that, in the final analysis, the only issue before the arbitrator is whether the Employer violated the Agreement. Further, while the Employer suggests that it did give the Union notice and the opportunity to bargain over MedChoice, this case, nevertheless, is not an 8(a)(5) or duty-to-bargain case since article 7(A)(1) allows the Employer to unilaterally make health benefit changes provided that the limiting "substantially similar" language holds: language that must be interpreted as being a "conditional" waiver to any right to bargain mid-term changes to health insurance benefits. *Columbia Hospital for Women*, 113 LA 980 (Hockenberry, 1999), *Health One-Mercy and Unity Hospitals*, 1993 WL 790277 (Bognanno, 1993), and *St. Cloud Hospital* (Bognanno, 2005).

Finally, the Employer requests that the grievance be denied.

VI. OPINION

The fighting issue in this case is whether the Employer violated article 7(A)(1) in the Collective Bargaining Agreement when, effective January 1, 2006, it implemented the MedChoice health insurance plan. The grievance itself also alleges violation of articles 1 (Recognition) and 3 (Management Rights) in the Agreement, but the evidence adduced in this case indicates that the Union implicitly dropped these charges and, therefore, they do not warrant further consideration.

The Union also contends that the Employer violated section 8(a)(5) of the NLRA by not negotiating MedChoice's terms prior to their implementation. This

charge can be easily disposed of by simple reference to the article 7(A)(1): the language that both parties acknowledge is at the heart of the instant issue. Article 7(A)(1) states:

> The Employer will provide comprehensive hospitalization, medical-surgical benefits and major medical insurance which shall be substantially similar to the benefits that are in effect as of the effective date of this Contract.

This is plain language. It provides that the Employer shall make available health insurance benefits. It also provides that the Employer may change these benefits provided that the resulting benefits are "substantially similar" to those that were available on the effective date of the current contract. This language clearly means that the Employer, by contract, may initiate unilateral and mid-term changes to health insurance benefits, provided that said changes are "substantially similar" to those being replaced. Therefore, based on the wording of article 7(A)(1), the Union explicitly waived its right to bargain the referenced health insurance benefit changes, but not its right to grieve alleged violations of article 7(A)(1)'s "substantially similar" condition.

Of course, it is possible that the NLRB could reach a different conclusion, but from the undersigned's perspective the issue at hand involves a breach of contract, and not a breach controlling federal labor law. *Health One – Mercy and Unity Hospitals*, *supra*. Thus, this facet of the case is dismissed, along with the need to discuss the timing and content of communications between the parties prior to MedChoice's implementation, and the need to identify which party might have carried the burden to negotiate. In any case, this genre of deliberation is best left to NLRB.

The Issue

Regarding article 7(A)(1), the Union takes the position that the Employer wrongly implemented MedChoice because it is not "substantially similar" to the pre-packaged health insurance plans that it replaced and, in particular, it is distinguished from Team Care. The Union's focus is on the benefit changes that in its view are dramatic. For example, it points to the change from three (3) pre-packaged plans to a single "flexible benefit" plan that incorporates 52 self-customized plans, and the change from three (3) to ten (10) coverage tiers. In addition, the Union contends that the 2006 MedChoice Plan is profoundly risky to the detriment of employees. The facts in evidence support this assessment.

First, approximately 75% of the bargaining unit's 2005 health insurance plan enrollees opted for the highest benefit plan design – highest monthly premium plan offered by the Employer (i.e., the Care Team plan with its $0 deductible, 100% co-insurance, nominal co-pays, and low out-of-pocket maximum features). Second, among the unit employees with 2005 insurance coverage, an even greater proportion, subscribed to the highest benefit plan design – highest monthly premium plan in 2006 (i.e., the MedChoice plan with the $0 deductible, 90%/70%/60% co-insurance, $0 co-pays and low out-of-pocket maximum features). In combination, these facts manifest a clear and secularly consistent propensity for risk-aversion on the part of the vast majority of unit employees. This is to say that these employees prefer paying high health insurance premiums in exchange for the peace of mind that comes with knowing that their uncertain, possibly high, future medical bills will be paid by their

insurance plan. In contrast, only a few of the unit's employees exhibit a preference for paying low health insurance premiums and running the risk that they may end up having to pay uncertain, possibly high, future medical bills out-of-pocket.

The record is lacking in historical morbidity and medical cost data for the employee group in question, and no one at the hearing provided prospective data of these sorts, which would have been needed to actuarially measure the difference, if any, in employee out-of-pocket health expenditures under the old and new health insurance regimes. Nevertheless, the Union claims that this is the case and to illustrate this point, it offered in evidence several tabulations, premised on realistic assumptions; and it produced witnesses that actually were adversely affected as a result of MedChoice's introduction.

However, since MedChoice does provide for less than 100% co-insurance coverage and given its higher out-of-pocket maximums, surely some bargaining unit members will (have) experience out-of-pocket medical expenses that will be greater than under Care Team. Qualitatively, MedChoice is the more risky plan design. Indeed, using somewhat stronger language, the Employer makes this same point when it advised as follows:

> All employees who enroll in Fairview MedChoice and use medical services during the year will pay more out-of-pocket than they do today because there is no longer a 100 percent coinsurance level.

(Union Exhibit 13).

The Employer responses to the Union are varied. First, the Employer points out that Mercer Consulting estimated a steep upward trend in the

Employer's aggregate medical care cost expenditures; and, as a consequence, the annual premium costs to employees would have increased by 7% between 2005 and 2006 without the implementation of MedChoice. (Employer Exhibit 11; Tr. 140). Indeed, the Employer points out, for the vast majority of unit employees who were insured in 2005, the level of 2006 employee-paid premiums actually fell as a result of MedChoice. Thus, qualitatively speaking, the Employer correctly argues that any 2005-to-2006 increment in out-of-pocket expenses should be calculated net of any decrement in employee-paid premiums, adjusting for the fact that the 2005 employee-paid premiums would have increased by 7% in 2006. Further, the Employer might argue that the referenced decrement in employee-paid premiums under MedChoice should mitigate the adverse effects of the previously discussed increase in employee risk.

Second, the Employer notes that there are many areas wherein (1) there were no health insurance changes, and (2) there were MedChoice-related changes that enhanced health plan benefits. Among the latter benefits are the following: that the positive correlation between employee premium costs and family size is relatively more equitable, and MedChoice's customization feature offers employees more choices than did the previous plans; that MedChoice offers employees a $0 co-pay feature; that MedChoice and the Open Access and High Deductible plans are indistinguishable; that the MedChoice has a larger provider network than did the Care Team plan; and that under Care Team there was no out-of-network coverage, as under MedChoice.

Finally, referencing Employer Exhibit 15, the Employer observes that a long-term past practice exists whereby the Employer has made numerous and similar changes to health insurance plans, and that this is the first time the Union has grieved.

Interpreting Article 7(A)(1)

Article 7(A)(1) requires that "The Employer will provide … insurance which shall be substantially similar to the benefits that are in effect …" (Joint Exhibit 1). The evidence and arguments adduced in this case make clear that the term "benefits" encompass both the panoply of insured health services (e.g., a day of hospitalization) and the associated out-of-pocket charges that the insured must pay for their use (e.g., a co-insurance payment). The Union's case rests mainly on the idea that the term "benefit" ought to be interpreted to mean health services per out-of-pocket payments, given its focus on MedChoice's altered deductible, co-insurance, co-pay, and out-of-pocket maximum terms. However, relying on arbitral precedence, the Employer maintains that the term "benefits" also encompass employee-paid premium costs, which are out-of-pocket payments the insured makes whether or not the health care system is accessed.

The undersigned agrees with the guidance offered by Graham and Fogelberg, among other arbitrators, who embrace the idea that the word "benefits" cannot be reasonably limited to exclude employee-paid premiums. *Clark County Sheriff, supra* @ 1504; and *Regina Medical Center, supra* @ 14. For many, if not most, insured employees their annual premium payments represent their single largest health-related out-of-pocket outlay; and their

premium payments are inextricably linked to the array of health services covered by their health insurance policy, and to the venues identified for insured health service access and delivery. Accordingly, in this case, the term “benefits” is interpreted to mean health services per out-of-pocket payments plus employee-paid premiums.

Referring to *Black’s Law Dictionary*, the Union submits that the term “substantially” is defined as “essentially, without material qualifications”, and that by extension any new health plan is “substantially similar” to the plan it replaced only if the changes are “minor” and “do not affect the overall administration and cost of employees of the plan”. (Union Brief @ 11). The Employer disagrees, arguing that the new plan may be broadly different in terms of design, coverage features, and employee premium costs provided that the plan modifications, considered in their totality, add up to a plan that is “substantially similar” to the previous plan. Among the arbitration awards cited by the Employer, the facts in *City of Reading, supra,* most closely parallel the facts in the instant case.

Apparently the City was facing a 26% increase in premium costs, so it decided to change health care providers in order to obtain lower prospective premiums *via* a plan with altered benefits coverage that, nevertheless, it believed to be “comparable to” the previous plan’s benefit levels, as required by the labor contract. As occurred in the instant case, some of City’s health insurance benefit levels were increased and others were decreased, with the insured in the bargaining unit being differentially affected. In applying the contract’s “comparable to” language, Arbitrator Paolucci concluded that to compare the old

and new plans, requires an "overall" analysis that includes consideration of both changes in benefit levels and premium costs. Given this conclusion, Arbitrator Paolucci's salient determination in *City of Reading* turned on an actuarial study the City had prepared, which quantitatively established that the two (2) health insurance plans were indeed similar, taken as a whole. *City of Reading, supra* @ 1583.

In this case, it is uncontroverted that the Employer's 2005 and 2006 health insurance plans are readily distinguishable, particularly when comparing Care Team's vs. MedChoice's design, benefit levels, and employee premium costs. Further, it is the opinion of this Arbitrator that this is the appropriate comparison to make because nearly 75% of insured 2005 employees opted for the former plan as opposed to the High Deductible and Open Access plans, and because an even larger percent of these employees opted for Care Team look-alike plans that are available under MedChoice.[10] Arbitrator Vernon might have ended this discussion at this point. His guidance can be read to suggest that the Union has successfully established that overall the two (2) plans do not provide "similar coverage" because, on their face, benefits like deductibles, co-pays and out-of-pocket maximums are materially different and, therefore, the grievance should be sustained, as he ruled in *Bison Gear and Engineering, supra* @ 7.

[10] In *Regina Medical Center, supra* @ 3, 4, and 10, Arbitrator Fogelberg found that the employer's new insurance plans included a so-called "Silver" plan, which was identical to the old insurance plan's "Level 1" option in which the vast majority of unit employees were enrolled. Construing the phrase "…benefits of such insurance plans…shall not be substantially diminished…", Arbitrator Fogelberg concluded that the word "plan" was a reference to the "Level 1" plan, renamed the "Silver" plan. *Regina Medical Center* is easily distinguished from the instant case. Only 25% of unit employees in this case were enrolled in the High Definition and Open Access plans in 2005, which the Employer repeatedly notes are the plans that most closely resemble MedChoice in design and coverage terms.

However, *Bison Gear and Engineering* is distinguished from the instant case in at least two (2) respects. First, the Employer points to past practices, which it argues are enforceable. Ultimately, however, this argument is not persuasive. It is true that in the past, the Employer has altered plan features and that the Union has never grieved. Further, the undersigned agrees that the phrase "substantially similar" ought to be interpreted in light of these practices. However, the health insurance changes that previously have been made have been periodic, nuanced and incremental in nature. By no stretch of the imagination can it be credibly argued that the Employer has previously implemented a stem-to-stern overhaul to its health insurance program, which is clearly what MedChoice represents. A comparison of the right-hand column in table 1 with the events itemized in Employer Exhibit 15 supports this conclusion. In addition, the Employer's numerous informational publications about MedChoice, and its extraordinarily long enrollment period, necessitated by the need to give employees ample time to absorb all of the new plan's features, corroborates this conclusion.

Second, uniquely central to the Employer's case is the role played by old *versus* new health plan premium costs, which must be considered along with changes in benefit levels in the analysis of overall plan differences: an argument the undersigned accepts. Further, it is clear that 2006 health insurance premium costs paid by employees are generally lower than the premium costs that employees were paying in 2005, and that they would be paying in 2006 since 2005 premium costs were slated to increase by 7%. Therefore, the Employer

theorizes, Care Team and MedChoice are "substantially similar" when considered on this overall basis.

However, the Employer does not prove this theory, as is its burden. Unlike *City of Reading, supra*, there is no actuarial study in evidence in this case to objectively supports the Employer's affirmative claim that overall the two (2) plans are "substantially similar". Accordingly, the undersigned draws three (3) overarching conclusions from this discussion. First, there is no doubt that the benefit coverage in MedChoice is different from the coverage in Care Team, particularly in the absence of 100% co-insurance and the larger out-of-pocket maximum, which even the Employer recognized exposes insured employees to greater risk of economic losses due to illness than was the case previously. Second, the general welfare of the affected workforce is diminished because of their exposure to this greater risk. Finally, even after adjusting for the differences in premium costs, out-of-pocket expenditures by insured employees may prove to be substantially larger under MedChoice, even on an overall basis.

Ultimately, these conclusions establish that the MedChoice health insurance plan materially qualifies the Care Team plan and, as such, the two (2) plans are not substantially similar.

The Remedy

As relief, the Union asks that the MedChoice Plan be rescinded; that the health insurance benefits in effect on March 1, 2005, be reinstated; and that the insured recover economic losses incurred because of MedChoice's implementation. This sought-after remedy seeks to reestablish the *status quo*

anti, but on a limited basis. That is, the Union does not propose that the affected employees, in most cases, should be responsible for paying the higher out-of-pocket premium costs that would accompany the restoration of the Care Team Plan and the other 2005 pre-packaged plans. However, any arbitral remedy handed down in this case will incorporate premium costs considerations. After all, if employees are to enjoy the benefits of the 2005 plans in 2006, they too must be responsible for their share of the 2006 premium costs for same. (*Scioto County Sheriff's Department, supra*).

Thus, in some instances, employees may have made 2006 out-of-pocket health service payments that they would not have made under their 2005 health insurance plans. In these cases, the Employer would be responsible for making whole said employees. Likewise, in some instances, employees may have made 2006 health insurance premium payments that are smaller than the 2006 premium payments they would have made under the 2005 health insurance plans. In these cases, the employees would be responsible for reimbursing the Employer for these differences. Of course, there doubtlessly are employees and dependents that have not used health services during 2006 and, as a consequence, while the Employer does not owe them for excess out-of-pocket payments, they may be required to reimburse the Employer for premium differences that may apply.

This non-exhaustive review of payments and cross-payments suggests an array of winner and loser combinations among employees, and between employees and the Employer, not to mention the heavy administrative burden

that the Employer, Union and employees would endure to faithfully comply with the Union's remedial proposal, as amended above by the undersigned. Therefore, there is room for bargaining. Accordingly, the undersigned is remanding this case to the parties with the directive that they endeavor to reach a negotiated settlement as to remedy.

VII. AWARD

For the reasons previously discussed, the grievance is sustained. The Employer violated article 7(A)(1) when it unilaterally implemented MedChoice on January 1, 2006. As for the remedy, the undersigned remands this case to the parties for the negotiation of an appropriate remedy, as previously discussed.

The remand period shall expire at the close of the business day on Friday, November 17, 2006. In addition, the undersigned shall retain jurisdiction over this case. In the event the parties are unable to enter into a mutually acceptable agreement as to the remedy, the undersigned will file an award in the form of a memorandum that will spell out the Union's remedy, as amended by the requirement that employees shall reimburse the Employer for any positive differences between the 2006 premium payments due under the 2005 health insurance plans (including 7% for inter-period premium inflation) and the actual premium payments they made under the MedChoice Plan.

Issued and ordered on the 29th day of August 2006, from Tucson, Arizona.

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Mario F. Bognanno, Labor Arbitrator

Appendix A

Table 1. Fairview Medical Plan Comparison Grid: 2005 Care Team Plan v. 2006 MedChoice Plan

(Source: Employer Exhibit 14 and Union Exhibit 6)

Variable	2005 Care Team Plan	2006 MedChoice
Plan Administrator	Preferred One	Preferred One
Type of Plan	Self insured: managed care plan	Self Insured: employee created plan
Plan Description	• Member select a primary care clinic from 1 of 8 care teams identified below • Each family member can select a different care team • Members can change care teams monthly • 100% coverage for many services within care team guidelines • Specialists within member's care team are 100% covered, following co-pay • Specialist referrals not needed within the Fairview Physicians Associates (FPA) and North Memorial Health Care (NMHC) teams • No coverage outside of member's selected care team	1. Preferred One Open Access 200 network of providers 2. Highest level of coverage for preventative and primary care: • FPA • University of MN Physicians (UMP) • North Clinic (NC) • NMHC • Access Quality Care Network (AQCN) • Health East Care System (HECS) • Aspen Medical Group (AMG) • Children's Physician Network (CPN) 3. Highest level of specialty care at: FPA and UMP 4.Members create own medical plan 5. Members chose level of deductible, medical co-insurance, office visit and pharmacy payments
Network Size	2,500 providers and 15 hospitals in eight care teams: • FPA • UMP • HECS • CPN • AQCN • NC • NMHC • AMG	Preferred One Network includes 10,000 providers and 150 hospitals
Calendar Year Deductible	None	Varies with plan design and deductible. Does not include office visit option, unless selecting "Deductible and co-insurance only" option.
Maximum Out-of-Pocket Per Calendar Year	Employee: $1,000 Employee + 1: $2,000 Family: $2,000 With 100% coverage thereafter	Varies by plan design option. Linked to deductible.
Preventive Care Services	100% coverage within care team guidelines	100% coverage within above-listed 8 care teams; other network providers covered at network office visit benefit level. Out-of-network not covered
Primary Care – Office Visits	$15 co-pay, then 100% coverage within care team guidelines	Above-listed 8 care team coverage at Choice Network level; other providers covered at network or out-of-pocket office visit benefit level.

Specialty Physician – Office Visit	$15 co-pay, then 100% coverage within care team guidelines	FPA and UMP care team coverage at Choice Network level; others covered at network or out-of-pocket office visit benefit level.
OB/GYN	100% coverage for preventative services. Self-referral allowed within care team guidelines.	Covered under preventative or primary care office visits
Maternity/Newborn	100% coverage for office visits and for Fairview and North Memorial hospitals inpatient care, with $100 hospital co-pay. 80% coverage at other care team hospitals, with $100 co-pay.	Depending on service, covered as either office visit or medical co-insurance.
Prescription Drugs	1. Co-pays at Fairview pharmacies: generic brands = $9; formulary brands = $18; and non-formulary brands = $35. 2. Co-pays at other network pharmacies: generic = $15; formulary brands = $30; and non-formulary brands = $45. 3. 80% co-insurance for selected injectable drugs	Depending on plan option, either: (1) deductible applies and pharmacy costs are combined with medical costs toward the annual out-of-pocket maximums; or (2) deductible does not apply and pharmacy costs do not go toward the annual out-of-pocket maximum. 1. At Fairview pharmacies: 80% co-insurance for generic brands ($5 min/$12 max); 75% co-insurance for formulary brands ($18 min/$30 max); 70% co-insurance for non-formulary brands ($35 min/$50 max). 2. At network pharmacies: 70% co-insurance for generic brands ($10 min/$20 max); 65% co-insurance for formulary brands ($30 min/$40 max); 60% for non-formulary brands ($45 min/$60 max). 3. 80% co-insurance coverage for selected injectable drugs, which is combined with medical costs toward the annual out-of-pocket costs.
Inpatient Hospital Services	$100 co-pay, then 100% coverage at Fairview hospitals and North Memorial. 80% co-insurance at other network hospitals within care team guidelines.	Option A Fairview: deductible, then 90% co-insurance. Network: deductible, then 70% co-insurance. Out-of-Network: deductible, then 60% co-insurance. Option B Fairview: deductible, then 80% co-insurance; Network: deductible, then 60% co-insurance. Out-of-Network: deductible, then 50% co-insurance. Co-insurance varies by plan design option.
Outpatient Hospital Services	$40 co-pay, then 100% coverage at Fairview hospitals and North memorial. 80% co-insurance at other network hospitals within care team guidelines.	See above Inpatient Hospital Services
Urgent Care Services	$15 co-pay	Following care teams are covered at the Choice Network level: FPA; UMP; NC; NMHC; AQCN; HECS; AMG; and CPN. Other providers covered at either network or out-of-network office visit benefit level.

Physical & Occupational Therapy	$15 co-pay, then100% coverage	See above Urgent Care Services Other providers covered at either network or out-of-network office visit benefit level or medical co-insurance. If outpatient service, then covered at medical co-insurance level.
Ambulance	Covered at 80% co-insurance.	Covered at 80% after network deductible.
Emergency Room Visits	At any care team hospital, $40 co-pay, waived if admitted. At a non-care team hospital, 20% co-insurance to $1,000 maximum.	See above Inpatient Hospital Services
Outpatient Mental Health	$15 co-pay per visit. Self-referrals within care team guidelines.	Office visits BHP/Fairview: Up to 40 visits per year. Network: Up to 30 visits per year. Out-of-network: Up to 30 visits per year. Note: Benefits will be reduced or denied if BHP authorization is not obtained.
Outpatient Chemical Dependency	$15 co-pay per visit. Self-referrals within care team guidelines.	Office visits Maximum of 130 hours per year. Note: Benefits will be reduced or denied if BHP authorization is not obtained.
Routine Eye Exam	100% coverage. Self-referrals within care team guidelines.	80% coverage after deductibles within network. No coverage out-of-network.
Out-of-Network	No out-of-care team coverage	Covered at out-of-network benefit level.
Maximum Lifetime Benefit	$1,000,000	$1,000,000
Palliative Care, Home Care, Durable Medical Equipments, TMJ, Weight Management, Smoking Cessation, Health Education Classes, Traveler Emergency Out-of-Area, Student Out-of-Area, etc.	Details Omitted.	Details Omitted.